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ACC NEWS

President's Page: What Is a Cardiologist?

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Sometime in the fall of 2008, I overheard a conversation regarding the recently administered cardiology board exam. The commentary expressed concern that there was too much emphasis on the electrocardiography (ECG) portion of the exam. The new cardiologist was mainly interested in imaging and felt that the exam content had little relevance to the skill in reading ECGs.

While my career has taken me through the experimental animal laboratory, the exercise laboratory, the catheterization laboratory, and the heart failure and transplant service, I have always maintained an outpatient practice where the ECG, a stethoscope, physical examination, and patient history were the key elements of patient diagnosis and management.

We used imaging studies to confirm or rule out a list of diagnostic choices in an already established differential diagnosis list or to determine whether one therapy or another would be a better choice. Generally, the most likely diagnosis was determined, the therapy choice made, and if the clinical data were assembled correctly, the images and other laboratory studies were confirmatory.

Clinical diagnosis is an art that depends on creating likelihoods for a list of diagnoses.

Clinical diagnosis is an art based on formal learning, data from guidelines and practice standards, experience, an understanding of the incidence of disease in the population that your patient represents, the relationship of symptoms to specific disease states, and the likelihood of a disease being present in a specific patient.

For example, a husband and wife saw me in the office to review their laboratory studies. Her studies reported a prostate-specific antigen. Upon questioning, I discovered that they were both in the blood laboratory at the same time. From that, I can surmise with high certainty that the names were switched on the labels. Should I repeat all the laboratory studies? By comparing this year's studies to their laboratory studies from the previous year, I could readily ascertain which current studies were hers and which belonged to him. Was there a risk in assuming these values were switched? Will clinical care be misdirected? Would they get billed by their insurance company for quickly repeated laboratory studies? By tying all of the information together, I was able to manage their cardiovascular disease and avoid having to ask them to delay a vacation trip to repeat the studies.

We in cardiology are being accused of overutilization of imaging. The accusation comes from a number of sources (1) and is based on data showing that the rate of growth in cardiovascular imaging exceeds the rate of growth in other imaging areas in medicine. The growth in imaging continues to increase the cost of health care.

We counter that imaging has improved the quality of our care and has saved lives, and that the value of reduced mortality and morbidity and restored productivity exceeds the cost of the imaging. After all, cardiology imaging is a small proportion of all imaging studies done in the U.S., so why does cardiovascular use get singled out for criticism?

Medicare statistics indicate that cardiovascular disease consumes almost one-half of the Medicare budget. Clearly this area becomes a target for cost reduction because of its significant impact on Medicare spending. Thus, we have seen reductions in echocardiography (echo) reimbursement through bundling of echo services. Now, although no data are yet available, nuclear imaging studies were recently reviewed. We can probably guess that the result will be some reduction in reimbursement that will be announced in the fall of 2009, leaving us little time to modify practice budgets for 2010.

How do you think cardiovascular professionals should respond? My opening comments provide a hint of my response to that question. I believe that we are relying too much on imaging data and numerical results of testing in managing patients with heart disease. A paper by Verghese (2) describes the problem of house officers who:

- direct their attention to images and numbers on a computer screen;
- pay little attention to making a direct evaluation of the patient's problems; and
- do not take the time to understand the broader context of the complaint or disorder.

To help us change this pattern of practice, the American College of Cardiology is developing appropriate use criteria not just for imaging, but also for therapeutic procedures. The first is the 2009 Appropriateness Criteria for Coronary Revascularization (3). These criteria are based on a combination of clinical information and study results. They demand a thorough understanding of the patient's medical status and history in order to properly apply the criteria in clinical scenarios.

Similar assumptions are inherent in the use of clinical practice guidelines. These documents are also meant to be practice aids to apply the current knowledge from clinical trials and expert consensus to the patient you are confronting with a cardiovascular disorder. Again, they are not intended to provide an answer to every patient's therapeutic needs. Rather, they are intended as an addition to the information base of the clinician faced with a decision about the best therapy for a cardiovascular disorder. The expert clinician integrates all of the information and each patient's unique status to decide the best therapy. In every case, thorough knowledge of the patient's history and the examination, laboratory, and imaging studies are essential for high-quality care.

I suggest that we define ourselves, first, as clinicians of the highest order. This means that we commit to providing individual patient care, that we get involved with our patients to provide continuity of care, and that we know our patients, their history, their family, and their work and behaviors—all of which add weight in the clinical decision process. Yes, we need to perform procedures, but we can hope that with new payment reform, we will no longer be driven to the laboratory to perform procedures to maintain income, and, instead, we will be properly reimbursed for providing continuous care and being excellent clinicians.

The American College of Cardiology is campaigning hard to move away from volume and intensity as the main criteria for payment and is emphasizing reimbursement for providing continuous high-quality care. I believe the result will be a continued provision of excellent care with a reduction in cost due to reduced overuse of imaging and procedures. Income lost from overuse will be made up by added reimbursement for care coordination and quality outcomes, as well as some adjustment for underuse of procedures and imaging based on guidelines and appropriate use criteria. It is likely that we will also increase our clinical activity as the many millions of uninsured and underinsured patients find their way to physicians who will be reimbursed for care that was previously free.

Do not lose sight of the fact that we are respected as clinicians. Our patients do not see us as imaging doctors or interventionalists alone. They see us as clinical care providers to whom they can come to for advice about their medical condition. They expect us to understand their condition, to provide or recommend safe, appropriate, and efficacious therapy, and to maintain their health status over time. As cardiologists, we need to meet those expectations.

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